Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

DATE: December 14, 2012

TO: Charles Palmer, Director

FROM: Jennifer Vermeer, Medicaid Director

RE: AFFORDABLE CARE ACT REPORTS

Please find attached a series of analyses and background studies related to the implementation of the Affordable Care Act (ACA). These reports are intended to support the public policy discussions of the ACA implementation in Iowa. The reports include:

- Four reports completed by Milliman, Inc., the actuarial firm contracted by the Iowa Medicaid Enterprise (IME). Three of these reports focus on the population and fiscal impacts to the state of the optional Medicaid expansion, and the fourth analyzes the impact of the optional Basic Health Plan.
- Nine reports completed by CSG Government Solutions and their subcontractors on ACA changes that impact Medicaid, as well as background studies focused on the implementation of Health Care Exchanges in Iowa.

The full reports are enclosed. A brief summary of each report is included below.

It is important to note that all of these reports are as of a point in time. The guidance from CMS is continually being updated as further clarifications and final rules are issued. Therefore, even now, some of the assumptions in these reports are outdated. For example, we asked Milliman to prepare a report on the impact of expanding Medicaid to 100% FPL rather than the full expansion to 138% FPL; a question that had long been unanswered by CMS. However, CMS issued a letter December 10, 2012 clarifying that this will not be an option for states. In addition, guidance on benchmark plans and essential health benefits also have not been finalized. These reports do not address the proposed regulations issued November 28, 2012. DHS will continue to monitor the guidance.

DHS Summary – December 14, 2012
Milliman Actuarial Reports

Optional Medicaid Expansion to 138% of the Federal Poverty Level (FPL)

This report provides estimates to the State of Iowa of implementing the optional Medicaid Expansion under the ACA. Due to the high degree of uncertainty in any estimates, the report provides a range based on a 'low scenario' and a 'moderate scenario'. Key findings:

- Medicaid enrollment would increase by between 110,000 to 181,000 over three years.

Net Estimated Fiscal Impact to the State: Expansion to 138% FPL

LOW SCENARIO
(Values in Millions)

Provision	Increase/(Decrease) Over Baseline State Spending							
	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	All Years
Currently Eligible ("Woodwork Effect")	10.7	45.0	60.0	58.8	61.2	63.6	78.1	377.4
Newly Eligible	(23.9)	(49.7)	(51.8)	(31.3)	(4.8)	4.8	25.2	(131.5)
Other Provisions/Administration	2.3	2.9	(13.6)	(21.8)	(22.6)	(23.8)	1.9	(74.7)
GRAND TOTAL	**(10.9)**	**(1.8)**	**(5.4)**	**5.7**	**33.8**	**44.6**	**105.2**	**171.2**

MODERATE SCENARIO
(Values in Millions)

Provision	Increase/(Decrease) Over Baseline State Spending							
	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	All Years
Currently Eligible ("Woodwork Effect")	17.4	74.4	100.6	100.4	106.5	113.0	142.3	654.6
Newly Eligible	(24.8)	(52.8)	(56.1)	(27.5)	11.8	27.1	59.1	(63.2)
Other Provisions/Administration	2.0	2.5	(9.5)	(18.4)	(19.4)	(21.2)	9.2	(54.8)
GRAND TOTAL	**(5.4)**	**24.1**	**35.0**	**54.5**	**98.9**	**118.9**	**210.6**	**536.6**

Key Assumptions:

- The enrollment impact estimates includes three key components:
  1. *'Woodwork Effect'* - An increase of 51,600 to 80,400, representing slightly less than half of the total increase (44% to 47%), due to increases in currently eligible populations not currently enrolled in Medicaid (the so-called 'woodwork effect').[1] These populations receive the usual federal match rate of approximately 58%.
  2. *Newly Eligible Adults* – An increase of 80,700 to 122,900 due to enrollment of adults newly eligible for Medicaid due to the Expansion. This population would receive the enhanced federal match rate of 100% in the early years, phasing down to 90% by 2020.
  3. *Movement to Exchange* – The report assumes that the state will enact policy changes that will move some groups currently covered by Medicaid to the Health Benefits

[1] **Iowa will very likely experience the enrollment and fiscal impact of the woodwork effect whether the Medicaid expansion is implemented or not, due to the outreach activity of the new Health Benefit Exchanges and media coverage of the law. The impact of the woodwork effect has not been included in any current Medicaid budget estimates.**

Exchange, and those members will access coverage and insurance tax subsidies available. This reduces Medicaid enrollment by an estimated 22,300.

- All estimates were updated from the December 2011 draft report to incorporate the most current 2010 Census data.
- The IowaCare program would be eliminated and those below 138% FPL would be shifted to the Medicaid Expansion; those above 138% FPL would be shifted to the HBE tax subsidy programs. The fiscal estimates include the IowaCare population shifted in the 'newly eligible' estimates; however, IowaCare enrollees are not included in the enrollment estimates because they are not considered an increase to current enrollment.
- Savings from eliminating IowaCare were limited to the current State appropriations of $8.5M. It was assumed that the state would not continue to receive Broadlawns property tax transfer revenue, or the savings due to University of Iowa Certified Public Expenditures.
- The 'take up' rates, or participation rates assumed in the analysis are very important and address subsets of the impacted populations differently. Please review assumptions detailed on Page 10 of the report to view the assumptions.
- Estimated average cost per person of $2,094 to $4,653 depending on population. The average cost per person for newly eligible adults is somewhat higher than what has been used in other national studies. DHS and Milliman consider these cost estimates to be more realistic based on the experience of the health status of adults currently covered in IowaCare.
- This report assumes some current eligibility groups receive the enhanced federal match rate which were not assumed in the December report. This is based on information reported by various sources, but not yet confirmed by CMS.

Significant fiscal impacts <u>not</u> addressed in this report:

- This report does not address the fiscal impact of continuing IowaCare if the Medicaid Expansion is not enacted. The estimated cost to the General Fund of continuing IowaCare after FY 2013 is estimated to grow substantially.
- This report does not address anticipated savings to counties. If the Medicaid Expansion is enacted, nearly all adults currently covered by counties' mental health programs would be eligible for Medicaid coverage, and a significant portion of the services costs currently born by counties would be shifted to the Medicaid expansion program. These services would receive the enhanced federal match rates provided under the ACA. This is anticipated to provide a significant financial savings to counties. This savings has not been addressed by Milliman.

DHS Summary – December 14, 2012
Milliman Actuarial Reports

Optional Medicaid Expansion to 100% of the Federal Poverty Level (FPL)

States have raised questions about whether states could expand Medicaid to 100% FPL rather than 138% FPL since the HBE tax credit subsidies begin at 100% FPL. This report provides estimates to the State of Iowa were the state to implement the optional Medicaid Expansion under the ACA up to 100% FPL rather than 138% FPL. **On December 10, 2012, CMS issued a letter to Governors with various clarifications on the ACA. That letter indicates that CMS will not consider expansions of anything less than 138% FPL**. Due to the high degree of uncertainty in any estimates, the report provides a range based on a 'low scenario' and a 'moderate scenario'. Key findings:

- Medicaid enrollment would increase by between 52,200 to 101,600 over three years.

Net Estimated Fiscal Impact to the State: Expansion to 100% FPL

LOW SCENARIO
(Values in Millions)

Provision	Increase/(Decrease) Over Baseline State Spending							
	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	All Years
Currently Eligible ("Woodwork Effect")	10.7	45.0	60.0	58.8	61.2	63.6	78.1	377.4
Newly Eligible	(23.9)	(49.8)	(51.7)	(40.9)	(26.5)	(22.1)	(11.3)	(226.2)
Other Provisions/Administration	1.6	1.5	(19.0)	(27.6)	(28.3)	(30.2)	(4.7)	(106.7)
GRAND TOTAL	**(11.6)**	**(3.3)**	**(10.7)**	**(9.7)**	**6.4**	**11.3**	**62.1**	**44.5**

MODERATE SCENARIO
(Values in Millions)

Provision	Increase/(Decrease) Over Baseline State Spending							
	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	All Years
Currently Eligible ("Woodwork Effect")	17.4	74.4	100.6	100.4	106.5	113.0	142.3	654.6
Newly Eligible	(24.9)	(52.8)	(56.1)	(41.7)	(21.7)	(15.2)	0.8	(211.6)
Other Provisions/Administration	1.3	1.0	(16.3)	(25.8)	(27.1)	(29.4)	0.3	(96.0)
GRAND TOTAL	**(6.2)**	**22.6**	**28.2**	**32.9**	**57.7**	**68.4**	**143.4**	**347.0**

Key Assumptions:

- Same assumptions as the analysis of expansion to 138% FPL. Population estimates adjusted for lower eligibility threshold.
- The enrollment impact estimates includes three key components:
  1. *'Woodwork Effect'* - An increase of 51,600 to 80,400, due to the so-called 'woodwork effect'.[2] These populations receive the usual federal match rate of approximately 58%. This assumption is the same as the 138% FPL report.

[2] **Iowa will very likely experience the enrollment and fiscal impact of the woodwork effect whether the Medicaid expansion is implemented or not, due to the outreach activity of the new Health Benefit Exchanges and media coverage of the law. The impact of the woodwork effect has not been included in any current Medicaid budget estimates.**

2. *Newly Eligible Adults* – An increase of 37,900 to 58,500 due to enrollment of adults newly eligible for Medicaid due to the Expansion. This population would receive the enhanced federal match rate of 100% in the early years, phasing down to 90% by 2020.
3. *Movement to Exchange* – The report assumes that the state will enact policy changes that will move some groups currently covered by Medicaid to the Health Benefits Exchange, and those members will access coverage an insurance tax subsidies available. This reduces Medicaid enrollment by an estimated 37,300.

- **CMS clarified on December 10, 2012, it will not allow states to have this option.**
- All other assumptions are consistent with what was used in the 138% FPL report. See above.

Significant fiscal impacts not addressed in this report (same as 138% FPL report):

- This report does not address the fiscal impact of continuing IowaCare if the Medicaid Expansion is not enacted. The estimated cost to the General Fund of continuing IowaCare after FY 2013 is estimated to grow substantially.
- This report does not address anticipated savings to counties. If the Medicaid Expansion is enacted, nearly all adults currently covered by counties' mental health programs would be eligible for Medicaid coverage, and a significant portion of the services costs currently born by counties would be shifted to the Medicaid expansion program. These services would receive the enhanced federal match rates provided under the ACA. This is anticipated to provide a significant financial savings to counties. This savings has not been addressed by Milliman.

DHS Summary – December 14, 2012
Milliman Actuarial Reports

Optional Medicaid Expansion – Comparison of Benchmark Benefit Plans

The ACA permits states options for the benefit package offered to newly eligible populations under the Medicaid expansion. This report is based on earlier information that states can choose whether to offer the same benefit package as offered in the current Medicaid program (the "Medicaid State Plan" package), or a benefit package equal to one of several 'Benchmark Plans'. This analysis provides a comparison of the cost of the Medicaid State Plan package vs. the State's Largest HMO package.

Please note: A CMS letter to Medicaid Directors released November 20, 2012, indicated that CMS does not intend to allow States to use their State plan in their exact forms. Rather states will be able to use a version of the State plan but will have to supplement each of the Essential Health Benefits (EHB) with the EHBs offered in one of the commercial options for the Medicaid benchmark. CMS has suggested that *States* would have to pay for benefits/services offered above the levels of Benchmark benefits. This potential fiscal impact is not addressed in this report. CMS expects to issue rules for the Medicaid Benchmark and EHBs "by the end of the year."

Due to the high degree of uncertainty in any estimates, the report provides a range based on a 'low scenario' and a 'high scenario'.

Net Estimated Fiscal Impact to the State: Benchmark Options

($ in millions)

Low Scenario								
	FY 14	**FY 15**	**FY 16**	**FY 17**	**FY 18**	**FY 19**	**FY 20**	**Total**
State Plan Package	$2.8	$6.4	$6.6	$31.3	$37.6	$44.4	$62.6	$191.7
Benchmark (Largest HMO)	$2.5	$5.6	$5.8	$27.4	$32.9	$38.8	$54.8	$167.8
Difference	$0.3	$0.8	$0.8	$3.9	$4.7	$5.6	$7.8	$23.9

High Scenario								
	FY 14	**FY 15**	**FY 16**	**FY 17**	**FY 18**	**FY 19**	**FY 20**	**Total**
State Plan Package	$4.6	$10.6	$11.2	$54.0	$66.2	$79.7	$114.6	$340.9
Benchmark (Largest HMO)	$4.0	$9.3	$9.8	$47.3	$58.0	$69.9	$100.5	$298.8
Difference	$0.6	$1.3	$1.4	$6.7	$8.2	$9.8	$14.1	$42.1

- The assumptions used in this report are consistent with the Milliman estimates for expanding Medicaid to 138% FPL.
- Using the Largest HMO benefit package has a lower cost than the current Medicaid benefit package.

- Important assumptions were made about the implementation of benefit packages for these estimates. Please review the report for detail on the assumptions used to generate these estimates.
- This policy decision has many impacts to consider regarding the differences in benefit plan coverage levels.

DHS Summary – December 14, 2012
Milliman Actuarial Reports

Basic Health Program Option

The ACA offers states the option of implementing a specific coverage program, the Basic Health Program (BHP), for persons between 138% FPL and 200% FPL. From Milliman's report, "The BHP can be used to bridge coverage between Medicaid/CHIP and products available through the Exchange, focusing on the population that is most at-risk of moving in and out of Medicaid eligibility because of changes in income." The BHP is limited to non-elderly individuals with income less than 200% of the Federal Poverty Level (FPL) who are not eligible for Medicaid or Employer Sponsored Insurance, with certain exceptions. Without BHP, these individuals would be eligible for coverage through the Exchange with subsidies, but with a higher premium and cost sharing.

The funding for BHP comes from Federal funding equal to 95% of the Federal subsidy the enrolled population would have received through the Exchange and Member premiums determined by the state. The BHP must provide at least the required essential health benefits. Premiums and cost sharing are limited and vary based on the member's income. The BHP may be offered by licensed HMOs, insurers, or a network of providers such as Accountable Care Organizations.

The benefit of the BHP is to bridge the so-called 'cliff' between Medicaid and coverage through the Exchange. Even with the subsidies in the Exchange, cost sharing is significantly greater than through Medicaid. The BHP allows states to provide a step between Medicaid and the Exchange to lessen the burden on this low income population. DHS asked Milliman to prepare this report to determine if a BHP could be cost neutral to the State of Iowa.

Key findings:

- BHP would cost the state additional funds if commercial insurers paying commercial level reimbursement rates to providers were used.
- BHP would not cost the state additional funds if Medicaid level fees were paid to providers, such as through Medicaid HMOs.
- These findings are very sensitive to two key assumptions – the health status of the population, and the assumed difference between Medicaid reimbursement rates and commercial rates. The report assumes Medicaid rates are 80.45% of commercial rates.
- The assumption of a healthier population or a lower ratio of Medicaid fees might make BHP financially neutral for the state if a Medicaid HMO is the carrier.
- DHS and Milliman collaborated on significant assumptions about benefit plans and cost-sharing for this report. Readers are encouraged to carefully review the full report in reviewing this option and the assumptions.
- CMS has not issued final rules for the BHP. Milliman relied on the proposed regulations and guidance available up to the point in time of the report.

DHS Summary – December 14, 2012
CSG Government Solutions Background Studies

DHS and the Iowa Insurance Division contracted with CSG Government Solutions to prepare various background studies that would support the State of Iowa in planning for the Health Benefits Exchange development under the Affordable Care Act (ACA). CSG subcontracted with other entities for some of these reports (noted in the reports). These studies were funded by the Health Benefits Exchange Level 1 Establishment Grant through the Federal Center for Consumer Information and Insurance Oversight (CCIIO).

There are nine reports. A summary of the contents of each report is included below:

Non-Modified Adjusted Gross Income – This report analyzes how Iowa's existing Medicaid and ***hawk-i*** eligibility categories align with the new Modified Adjusted Gross Income (MAGI) eligibility standard under the ACA. The report explores possible options for simplifying eligibility categories for the non-MAGI population.

Essential Health Benefits – The ACA requires all health insurance plans sold to individuals and small businesses to meet minimum benefit requirements. The law establishes a benefit package of Essential Health Benefits that must include coverage of ten broad categories of care. Rather than establishing a single national standard benchmark plan, each State will choose its own specific benchmark from ten options. This report includes a review of all ten potential benchmark benefit plans to identify which services are included in the plans. As noted above, this report is subject to the changes indicated in the November 20, 2012 Medicaid Director's letter and that will be clarified with the rulemaking expected by the end of CY 2012.

Medicaid Benchmark – This report provides information regarding the State's decision about the benefit package that would be adopted for the optional Medicaid Expansion. It examines three alternative Medicaid benchmark benefit plans that may be considered and provides an analysis of differences in benefits from a health care perspective. Finally it analyzes the cost implications of each option. This report is augmented by the more detailed financial analysis provided by Milliman, Inc. As noted above, this report is subject to the changes indicated in the November 20, 2012 Medicaid Director's letter and that will be clarified with the rulemaking expected by the end of CY 2012.

Basic Health Program (BHP) Options – The report identifies and discusses policy, strategic, and financial issues that should be considered in making a decision about whether to implement a BHP in Iowa. This report is augmented by the more detailed financial analysis provided by Milliman, Inc. Note: The data sources were different for each report, therefore some of the estimates have slight differences.

Navigator – The ACA includes requirements for extensive consumer assistance, marketing and outreach activities including requirements that Exchanges establish Navigator programs. This report examines options for a Navigator program in Iowa and a high-level operational timeline.

Small Business Health Options Programs (SHOP) – This report discusses the statutory, regulatory and administrative requirements of the SHOP Exchange, including the employer and employee application process, eligibility determinations, enrollment, and premium billing and collection. It discusses three major design decisions facing a SHOP Exchange in Iowa.

Program Integrity – This report provides an Internal Control Blueprint for a State-Based Health Benefits Exchange. As IT systems or business processes have not been identified, many

recommendations in this report represent best practices in designing and developing an internal control system to prevent and detect fraud, waste and abuse.

Iowa's Current Health Coverage Marketplace: Background Research – This report, also known as Milestone Two, comprises analysis of current population statistics and detailed modeling simulations to provide specific demographic profiles of the insured and the uninsured. Further, David P. Lind Benchmark and Data Point Research, Inc. conducted the 2012 Iowa Health Insurance Survey which helped illuminate Iowa's population of underinsured to help model how the uninsured and underinsured may react to the Exchange. This report contains a wealth of data and information about Iowa's population and health insurance coverage.

Iowa's Current Health Coverage Marketplace: Background Research and Simulation Modeling - This report, known as Milestone Seven, consists of an analysis of the ramifications of the Affordable Care Act (ACA) on Iowa's insurance market. It was prepared by David P Lind Benchmark, Data Point Research, and Magnum Actuarial Group. The report provides analysis of options for Iowa, and models the impact of options on Iowa's insurance market including benefits and challenges.